MEDICAL RE	CORD			CONSULTA			OCAL REPRODUCTION
WIEDICAL RE	CORD				I ION SHEET		
TO:				REQUEST		DATE OF	DEOLICET
TO:			FROM: (Re	questing physician or acti	vity)	DATE OF	REQUEST
REASON FOR REQUEST (Complaints	and findings)					
PROVISIONAL DIAGNOSI	S						
DOCTOR'S SIGNATURE			APPROVED	PLACE OF CONS	ULTATION		
					_	ROUTINE	TODAY
				BEDSIDE	ON CALL	72 HOURS	EMERGENCY
		1		TATION REPORT	ı		
RECORD REVIEWED	YES	NO	PATIENT EX	AMINED YES	NO	TELEMEDICINE	YES NO
			(Continue	e on reverse side)			
SIGNATURE AND TITLE							DATE

RECORDS MAINTAINED AT

SPONSOR'S NAME (Last, first, middle)

(For typed or written entries, give: Name -- last, first, middle; ID no. (SSN REGISTER NO. or other); Sex; Date of Birth; Rank/Grade)

HOSPITAL OR MEDICAL FACILITY

RELATION TO SPONSOR

PATIENT'S IDENTIFICATION

CONSULTATION SHEET

DEPARTMENT/SERVICE OF PATIENT

Medical Record

SPONSOR'S ID NUMBER (SSN or Other)

WARD NO.

				Fo	ır iisə					RD-SUF										Gene	·al					
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